New Jersey Department of Health and Senior Services
HealthStart Program
PO Box 364
Trenton, NJ 08625-0364

APPLICATION FOR A HEALTHSTART MATERNITY CARE PROVIDER CERTIFICATE

(Please type or print all information in ink.)

1. * Name of Applicant (Agency, Private Practice, Group Practice)		2. ** Medicaid Billing No.(from billing form)	
3. Mailing Address of Applicant		4. Site Location Within Agency or If Different Than Mailing Address	
5. City, State, Zip Code	County	6. City, State, Zip Code	County
7. Name of Principal Administrative Contact		8. Title of Principal Administrative Contact	
9. Business Telephone Number ( )		10. Receiving NJDHSS Maternal and Child Health Services Grant Funding for Prenatal Care? 1☐Yes 2☐No	

11. Type of Certificate Requested

- 1 ☐ Comprehensive HealthStart Package (Obstetrical & Health Support Service)
- 2 ☐ Full Medical Maternity
- 3 ☐ Delivery Only
- 4 ☐ Health Support Service Component Only (Must complete Item 15 below)

12. Type of Provider (Check ALL that apply)

- a ☐ Solo Practice
- b ☐ Group Practice
- c ☐ Licensed Ambulatory Care Center
- d ☐ Local Health Department
- e ☐ Hospital Clinic in which physician(s) DO NOT bill independently for their services (Bundled).
- f ☐ Hospital Clinic in which physician(s) DO bill independently for their services (Unbundled).
- g ☐ Other (specify) _____

13. Place of Practice (Check ALL that apply)

- a ☐ Private Office
- b ☐ Hospital-Based
- c ☐ Independent Clinic-Based

14. Estimated number of deliveries per year: _____

Number of Medicaid deliveries: _____

a. Is this a specialty service? 1 ☐ Yes 2 ☐ No

b. If Yes, identify type: 1 ☐ High-Risk 2 ☐ Adolescent 3 ☐ Other (Specify) _____

15. If not applying for a Comprehensive HealthStart services certificate, fill out the following information and attach signed Provider Agreement.

Name of Provider of Other Services	Date Co-Application Sent	Will All Services Be Provided At One Location?	Currently Have HealthStart Certificate?
		1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

16. If comprehensive maternity care services are being provided at <u>two</u> sites, indicate the following:

a. Site Address of Other Component

_____

_____

_____

* For group practice, applicant should use name recognized by Medicaid.
** If group practice, must be number issued by Medicaid for the group.

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b. Policies and procedures are in place for:

(1) Case conferences 1 ☐ Yes 2 ☐ No

(2) Ensuring follow-up on patient problems 1 ☐ Yes 2 ☐ No

17. Days/Hours of Operation for maternity care service: _____

18. If applying for a comprehensive certificate, are you requesting to do presumptive eligibility determination?
(NOTE: THIS IS ONLY AVAILABLE FOR NON-PHYSICIAN PROVIDERS OF COMPREHENSIVE SERVICES.)
1 ☐ Yes 2 ☐ No

GENERAL SERVICES (TO BE COMPLETED BY ALL APPLICANTS)

1. Job descriptions are in place for all staff providing HealthStart services: 1 ☐ Yes 2 ☐ No

2. Policies and procedures are in place for:

a.	Conducting uniform risk assessments	a. 1 ☐ Yes 2 ☐ No
b.	Confidentiality of records and care	b. 1 ☐ Yes 2 ☐ No
c.	Informed consent	c. 1 ☐ Yes 2 ☐ No
d.	The patient to receive an initial appointment with medical provider within 2 weeks of request	d. 1 ☐ Yes 2 ☐ No
e.	Arrangements for language interpretation	e. 1 ☐ Yes 2 ☐ No
f.	Conducting outreach activities	f. 1 ☐ Yes 2 ☐ No
g.	Completion of Plan of Care within 1 month of initial visit	g. 1 ☐ Yes 2 ☐ No
h.	Transfer of patient record to hospital of delivery no later than 34 weeks gestation	h. 1 ☐ Yes 2 ☐ No
i.	Receipt of hospital record summary no later than 2 weeks postpartum	i. 1 ☐ Yes 2 ☐ No
j.	Transfer of pertinent maternal/infant history to pediatric or other continuing care providers	j. 1 ☐ Yes 2 ☐ No
k.	Linkage for each infant with a pediatric care provider	k. 1 ☐ Yes 2 ☐ No
l.	Linkage with future family planning services as needed	l. 1 ☐ Yes 2 ☐ No
m.	Recording all patient contacts and visit content in patient record	m. 1 ☐ Yes 2 ☐ No
n.	Processing of clinical claims information to Billing Unit	n. 1 ☐ Yes 2 ☐ No

3. A uniform Plan of Care containing all the required content is available and part of the patient record. (Attach sample of Plan of Care Tool) 1 ☐ Yes 2 ☐ No

MEDICAL CARE SERVICES (TO BE COMPLETED BY ALL APPLICANTS)

1. Staffing pattern to be used for providing obstetrical care (Check ALL that apply):

1 ☐ Physicians in private practice 4 ☐ Attending Physicians

2 ☐ Staff Physicians 5 ☐ Certified Nurse Midwives

3 ☐ Resident Physicians 6 ☐ Other (Specify) _____

2. Total number of obstetrical care provider hours available during days/hours of operation (Question 17 above): _____ Hours

3. List all individual obstetrical care providers who will provide HealthStart ambulatory care services:
(Attach additional pages if necessary)

Name	Medicaid Provider Number	License Number	Hospital Generally Used for Delivery	OB Admitting Privileges?	Prov. Type*
				1 ☐ Yes 2 ☐ No	
				1 ☐ Yes 2 ☐ No	
				1 ☐ Yes 2 ☐ No	
				1 ☐ Yes 2 ☐ No	
				1 ☐ Yes 2 ☐ No	

*NOTE: Provider Type Codes: OB=Obstetrician FP=Family Practitioner CNM=Certified Nurse Midwife OTH=Other

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4. List all clinicians who will provide delivery service if different than those named in Question 3.

Name	Medicaid Provider Number	License Number	Hospital Generally Used for Delivery	OB Admitting Privileges?	Prov. Type*
				1 ☐ Yes 2 ☐ No	
				1 ☐ Yes 2 ☐ No	
				1 ☐ Yes 2 ☐ No	
				1 ☐ Yes 2 ☐ No	
				1 ☐ Yes 2 ☐ No	

*NOTE: Provider Type Codes: OB=Obstetrician FP=Family Practitioner CNM=Certified Nurse Midwife OTH=Other

5. Indicate hospital(s) providing high-risk delivery services for your patients.

_____ _____

_____ _____

6. Identify provider(s) to be used for high-risk prenatal services if other than self:

_____

_____

7. Policies and procedures are in place for:

a. 24-hour access for emergency medical care 1 ☐ Yes 2 ☐ No

b. Management and consultation for medical high-risk patients 1 ☐ Yes 2 ☐ No

c. Transfer of care for medical high-risk patients 1 ☐ Yes 2 ☐ No

d. Emergency neonatal consultation and/or services 1 ☐ Yes 2 ☐ No

8. Identify which perinatal record will be used for documenting services:

1 ☐ POPRAS 2 ☐ Hollister 3 ☐ Other (Attach copy)

9. Routine laboratory specimens are collected on site:

1 ☐ Yes 2 ☐ No

If No, indicate where this is done:

_____

10. Policies and procedures are in place for providing required special tests and procedures:

1 ☐ Yes 2 ☐ No

If applying for a HealthStart Full Medical Maternity Services or Delivery Only Certificate, skip to Page 6 of this application and complete Signature Section.

HEALTH SUPPORT SERVICES TO BE COMPLETED

All basic services are to be provided during regular hours of operation.
PATIENTS SHOULD NOT BE EXPECTED TO RETURN FOR ANOTHER VISIT TO RECEIVE BASIC SERVICES.

SECTION A. CASE COORDINATION

1. Indicate the required minimum qualifications for a case coordinator according to your agency's job description (check all that apply):

1☐ Registered Nurse

2☐ Bachelor's or Graduate Degree in Social Work

3☐ Bachelor's or Graduate Degree in a Health Science (Specify degree and field) _____

4☐ Bachelor's or Graduate Degree in a Behavioral Science (Specify degree and field) _____

5☐ Other (Specify) _____

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2. Indicate any responsibilities that your case coordinator(s) will be performing, over and above case coordination:

1 ☐ Nursing Service
2 ☐ Obstetrical Care
3 ☐ Basic Social/Psychological Service
4 ☐ Basic Nutrition Service
5 ☐ Home Visiting
6 ☐ Health Education
7 ☐ Specialized Social/Psychological Service
8 ☐ Specialized Nutrition Service
9 ☐ Administration/Management
10 ☐ Other (Specify) _____

3. Total staff time available for case coordination services including documentation: Hours/week _____

4. Will paraprofessional staff members be assisting with case coordination? 1 ☐ Yes 2 ☐ No

   a. If Yes, total paraprofessional staff time available: Hours/week _____

5. Policies and procedures are in place for:

a.	Assignment of a case coordinator for each patient	a. 1 ☐ Yes 2 ☐ No
b.	Orientation of patients to services and their rights and responsibilities	b. 1 ☐ Yes 2 ☐ No
c.	Coordination with specialized nutrition and social/psychological services	c. 1 ☐ Yes 2 ☐ No
d.	Completion of assessments, development and revision of Plan of Care	d. 1 ☐ Yes 2 ☐ No
e.	Follow-up on missed appointments	e. 1 ☐ Yes 2 ☐ No
f.	Follow-up on incomplete referrals	f. 1 ☐ Yes 2 ☐ No
g.	24-hour access to case coordination for emergency situations	g. 1 ☐ Yes 2 ☐ No
h.	Preventive postpartum health care contact prior to medical postpartum visit	h. 1 ☐ Yes 2 ☐ No
i.	Completion and submission of HealthStart Maternity Services Summary Data form	i. 1 ☐ Yes 2 ☐ No
j.	Referrals for home visits	j. 1 ☐ Yes 2 ☐ No

6. Identify the agency which will provide Preventive Health Care home visits:

1 ☐ Self (HealthStart provider)
2 ☐ Other (Specify and attach Letter of Agreement)

_____

   a. If preventive health care home visits are to be provided by the HealthStart provider, identify all staff providing services:

1 ☐ Registered Nurse
2 ☐ Certified Nurse Midwife
3 ☐ Social Worker
4 ☐ Paraprofessional
5 ☐ Other (Specify) _____

7. Please indicate if policies and procedures are in place for provision or referral for the following extensive specialized testing and/or counseling services. Also, indicate those services which are available within your own organization.

		Policies and Procedures for Provision or Referral	Available Within Own Organization
a.	Alcohol abuse	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
b.	Substance abuse	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
c.	Parenting skills	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
d.	Family/social services	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
e.	Mental health	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
f.	Smoking cessation	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
g.	AIDS	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
h.	Genetic	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
i.	Family planning	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
j.	WIC	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
k.	Other nutrition	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
l.	Employment/education	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
m.	Other (Specify): _____	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

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SECTION B. HEALTH EDUCATION SERVICES

1. Indicate the required minimum qualifications for individuals providing health education services according to your agency's job description (check all that apply):
   - 1 ☐ Registered Nurse
   - 2 ☐ Bachelor's Degree in Health Education
   - 3 ☐ Certified Childbirth Educator
   - 4 ☐ Bachelor's Degree in Social Work Plus _____ Years Experience
   - 5 ☐ Bachelor's Degree in a Health or Behavioral Science Plus _____ Years Experience
   - 6 ☐ Other (Specify) _____
2. Total staff time available for health education services including documentation: Hours/week: _____
3. Policies and procedures are in place for:
   - a. Utilization of a standard tool within your agency for recording health education assessment (attach copy) 1 ☐ Yes 2 ☐ No
   - b. Implementation of the health education instruction curriculum 1 ☐ Yes 2 ☐ No
   - c. Providing or arranging for a full childbirth education course at no cost to patient 1 ☐ Yes 2 ☐ No
4. The childbirth education course will be provided by:
   - 1 ☐ HealthStart provider unit
   - 2 ☐ Another unit within the parent organization
   - 3 ☐ By referral to another agency (Specify)

SECTION C. SOCIAL/PSYCHOLOGICAL SERVICES

1. Indicate the required minimum qualifications for individuals providing basic social/psychological services according to your agency's job description (check all that apply):
   - 1 ☐ Registered Nurse
   - 2 ☐ Bachelor's Degree in Social Work
   - 3 ☐ Bachelor's Degree in a Health Science Plus _____ Years Experience
   - 4 ☐ Bachelor's Degree in a Behavioral Science Plus _____ Years Experience
   - 5 ☐ Other (Specify) _____
2. Total staff time available for <u>basic</u> social/psychological services including documentation: Hours/week _____
3. Specify the qualifications for individuals providing specialized social/psychological services according to your agency's job description: _____
4. Total staff time available for specialized social/psychological services including documentation: Hours/week _____
5. Policies and procedures are in place for:
   - a. Utilization of a standard tool within your agency for recording social/psychological assessments (attach copy) 1 ☐ Yes 2 ☐ No
   - b. Development and implementation of the social/psychological component of the Plan of Care 1 ☐ Yes 2 ☐ No
   - c. Providing basic social/psychological guidance services 1 ☐ Yes 2 ☐ No
   - d. Identification of the need and provision of specialized social psychological services 1 ☐ Yes 2 ☐ No

SECTION D. NUTRITION

1. Indicate the required qualifications for individuals providing basic nutrition services, according to your agency's job description (check all that apply):
   - 1 ☐ Registered Nurse
   - 2 ☐ Bachelor's Degree in Nutrition
   - 3 ☐ Bachelor's Degree in Social Work, Health or a Behavioral Science Plus _____ Years Experience
   - 4 ☐ Other (Specify) _____
2. Total staff time available for <u>basic</u> nutrition services including documentation: Hours/week _____
3. Specify the qualifications for individuals providing specialized nutrition services according to your agency's job description: _____
4. Total staff time available for specialized nutrition services including documentation: Hours/week _____
5. Policies and procedures are in place for:
   - a. Utilization of a standard tool within your agency for recording nutrition assessments (attach copy) 1 ☐ Yes 2 ☐ No
   - b. Providing basic nutrition guidance 1 ☐ Yes 2 ☐ No
   - c. Identification of the need and provision of specialized nutrition services 1 ☐ Yes 2 ☐ No
   - d. Development and implementation of the nutrition component of the Plan of Care 1 ☐ Yes 2 ☐ No

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Name of Applicant	Medicaid Billing No.

This is to certify that HealthStart service activities described in this application will be available on

_____ and will:
(date)

-Be performed in accordance with NJAC 10:54-6.1 through 6.19 and the New Jersey Department of Health and Senior Services "HealthStart Program Guidelines;"

-Include participation in HealthStart evaluation and quality assurance activities;

-Include staff participation in HealthStart training sessions;

-Include written notification to the New Jersey Department of Health and Senior Services if unable to continue providing HealthStart services as described in this application;

-Be billed to Medicaid for only those services provided in accordance with HealthStart (HCFA) (HCPCS) assigned billing codes.

Name of Chief Executive Officer *	Title
Signature	Date

*For solo or group practices, Chief Executive Officer is the physician with administrative responsibility.

Name of Administrator **	Title
Signature	Date

** Administrator directly responsible for providing HealthStart services.

NOTE: PLEASE BE ADVISED THAT HEALTHSTART STAFF MAY BE MEETING WITH YOU OR YOUR STAFF PRIOR TO, DURING, OR AFTER RECEIPT OF THIS APPLICATION TO DETERMINE HOW SERVICES ARE PROVIDED. PLEASE HAVE AVAILABLE FOR THE MEETING A DESCRIPTION OF YOUR SERVICE IN TERMS OF APPROACH TO PROVIDING HEALTHSTART SERVICES, I.E., ORGANIZATIONAL STRUCTURE, SEQUENTIAL ORDER OF VISITS, PURPOSE OF VISIT TIME IN EACH SEGMENT, STAFF, ETC.

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